

Focus: Current issues in medical ethics

The idea of a happy death is one that startles and disgusts modern man. However, although that phrase is not often used today, that is what the Archbishop of Canterbury, Dr Donald Coggan, is to some extent considering in his Edwin Stevens lecture given to the Royal Society of Medicine. We are publishing extracts from that lecture by kind permission of the President of the Royal Society of Medicine. We have chosen those passages in the lecture which discuss the limits of the doctor's responsibility to keep a patient alive, the erroneous idea that Christians believe in the artificial prolongation of life in all circumstances, and the most delicate question of the choice of patients who shall receive the costly benefits of modern medical technology.

On dying and dying well: Extracts from the Edwin Stevens lecture

Donald Coggan

The title of this lecture—*On Dying and Dying Well*—was suggested by the title of a report of a working party set up by the Board for Social Responsibility of the Church of England¹ which formed the subject of a debate in its General Synod in February 1976. I have given this title to this lecture because it seemed to me to sum up, perhaps better than any other form of words, what the President of the Royal Society of Medicine had in mind when he wrote to me a year ago.

I make what small contribution I can today out of the conviction that much hard thinking remains to be done on this subject, and that we shall only work our way towards positive and helpful principles in so far as practitioners in various departments of life and learning join their skills and marry their experiences in the give and take of open discussion. I speak as one who, unlike those who have spoken before me this evening,² has no scientific or legal expertise, but as one who, in a ministry as priest and bishop extending well over 40 years, has often come close to those who are dying and is deeply concerned that the act of dying should be as good an act as preparation and skill and love can make it. I speak as a Christian, with all the bearing that Christian belief and practice have on our subject. But I am convinced that the major part of what I shall say has relevance for those who do not hold the

Christian faith, or only partially do so, and much of it for those who cannot even subscribe to that view of death which is summed up in the words *Vita mutatur, non tollitur*,³ 'Life is changed, not taken away' by the incident of death.

Limits of the doctor's responsibility to keep alive

It might be of help if, at the outset, I said a word about the limits to the doctor's responsibility to keep his patient alive, and what Christian moralists have to say on the subject. I refer first to some words contained in the Papal Allocution of Pope Pius XII to a congress of anaesthetists which met in November 1957, and I quote from the booklet *Decisions about Life and Death: A problem in Modern Medicine*:—⁴

'The Pope was considering *inter alia* certain moral questions that may arise through the use of artificial respiration in cases of cerebral lesion. A patient has been plunged into unconsciousness by central paralysis, artificial respiration has been applied so as to maintain his breathing and circulation, but after several days of treatment there is no sign or prospect of any improvement in his condition. In such circumstances may the apparatus that is maintaining the circulation be removed, or ought it to be kept in operation until the circulation stops in spite of it?

'The answer given in the allocution was based on the distinction, already drawn by Roman Catholic moralists, between "ordinary" and "extraordinary" medical or surgical procedures. "Ordinary" in this context does not mean what a medical man would regard as "normal" treatment: it means whatever a patient can obtain and undergo without thereby imposing an excessive burden on himself or others. Thus "extraordinary" treatment has been defined as "whatever here and now is very costly or very unusual or very painful or very difficult or very dangerous, or if the good effects that can be expected from its use are not proportionate to the difficulty and inconvenience that are entailed".

'The point of the distinction is this. As a general rule a sick man is bound, as are those who have the care of him, to employ the appropriate available means of preserving his life and restoring his health. But there are obviously limits to this obligation. He is not bound to incur, or impose upon his family,

an impoverishing expense; nor is he bound to submit to treatment which would cause him great distress and of which the benefits are problematical. In other words his strict obligation extends only to the "ordinary" means of preserving life and restoring health, and not to the "extraordinary" as defined above. He may accept "extraordinary" treatment if he thinks fit; but he is not bound to do so, unless he has some special obligation to stay alive. As for those who have the care of the patient, the doctor has neither right nor duty to insist on "extraordinary" treatment against the patient's will, nor is he bound to apply such treatment in cases where the patient cannot be consulted; and the patient's family is in much the same position.⁷

Though there are obvious difficulties in the outworking of the principles enunciated in this allocution, there are marked similarities between them and the attitude reflected by the Anglican canon lawyer, Chancellor E Garth Moore, when dealing with another aspect of the same problem, namely, the legitimacy of action taken by a doctor which may lead to the shortening of the patient's life. The useful ethical distinction between a principal intention, or moral object, which is good, and indirect consequences, may throw light on the nature of the decision facing the doctor who wishes to give a pain-killing drug to a patient. Garth Moore writes:—

'It would seem reasonably certain that the giving of a pain-killing drug to a patient *in extremis* can be justified, not only by the theologian's law of double effect, but also by the Common Law doctrine of necessity, even where one of the effects of the drug is the probable shortening of the patient's life. This is because the evil averted, namely the agony of the patient, is greater than the evil performed, namely an act leading to the probable shortening of his life. . . .'⁵

The first two *Conclusions* of the signatories of the Report *On Dying Well* (to which allusion has already been made) also show marked similarity to the general conclusions both of Pope Pius XII and of Chancellor Garth Moore. They read:—

'(1) In its narrow current sense, euthanasia implies killing, and it is misleading to extend it to cover decisions not to preserve life by artificial means when it would be better for the patient to be allowed to die. Such decisions, coupled with a determination to give the patient as good a death as possible, may be quite legitimate.

'(2) Nor should it be used to cover the giving of drugs for the relief of pain and other distress in cases where there is a risk that they may marginally shorten the patient's life. This too we think legitimate'.⁶

This is in keeping with the point made by the Bishop of Truro in introducing the debate on the Report, when he said: 'The demands that a patient *in extremis* should not be subjected to troublesome

treatment which cannot restore him to health and that doctors may use drugs to control pain even at the risk of shortening life do not involve voluntary euthanasia at all and are not in question.'⁷

Christians do not believe in artificial prolongation of life in all circumstances

In the light of these references, I need hardly emphasize that the view, held by many, that Christians believe that life must be artificially prolonged under all circumstances is not true. You will recall the case of the American girl, Karen Quinlan, which was widely reported in the press last year. I am informed that it was the doctors, not the priest, who gave advice which led to the prolongation of her life. Probably all of us would agree in deploring the events which so fearfully prolonged the life – if life it can be called – of General Franco. A similar case of malpractice is described in a letter quoted by Hugh Trowell in his important and sensitive book *The Unfinished Debate on Euthanasia*.⁸ He rightly describes the letter as 'terrible'.

Lord Edmund-Davies has already quoted Arthur Hugh Clough's words:—

'Thou shalt not kill, but need'st not strive
Officiously to keep alive.'^{*}

However great the difficulties in law of working out the implications of these oft-quoted lines, there would seem to be a wide consensus of Christian opinion in favour of the principles contained in them.

Choosing the recipients of advanced medical technology

There is another matter, closely related to the one which we have just been considering, which must cause anxiety, and at times perhaps agony, to a doctor who has to weigh up his responsibility in making a choice. I refer to the choice between, on the one hand, making the most advanced techniques available to a few, and, on the other hand, improving the level of services available to many, and especially to those who have in the past been inadequately cared for. The resources of the national exchequer are not limitless,^{**} and the prolongation of the life of one aged patient may in fact entail the deprivation

^{*} These lines of Arthur Hugh Clough are from *The Latest Decalogue*. They are frequently quoted, with some solemnity, in books and papers on euthanasia and kindred subjects. The author would I think, have been amused, for Clough's *Decalogue* is satirical, one might almost say cynical. See, for example, the last of his 'commandments':—

'Thou shalt not covet, but tradition
Approves all forms of competition'!

^{**} In the year 1975/76 the nation spent £4564 million on health and welfare (including local authority costs).

of aid to others and even the shortening of their lives. Nor are beds in hospitals limitless; and the extension of the life of a terminal patient may necessarily involve the suffering or even death of those who, if speedily admitted to hospital treatment, might have many years of useful life ahead of them.

I realize that here I am treading on exceedingly dangerous ground. I am fully aware of the great dangers of legalized euthanasia. I bear in mind a passage in Sir Norman Anderson's recent book *Issues of Life and Death*⁹ in which he writes that, if voluntary euthanasia were to be made legal,

'... there would soon be a demand for further concessions. It would not be long before the argument would be heard that paralysed, incontinent or semi-comatose elderly persons would certainly sign the suitable form if only they were to have a sufficiently lucid interval; so why should not their relatives do for them what they would wish to do for themselves? "That agreed" – to quote a recent article by R F R Gardner – "within a month someone would say, "But to expect relatives to make this decision is to impose an impossible emotional burden; let us authorise an official to do this without distressing them". Naturally parallel arguments would be advanced for the congenitally damaged neonates. It would then be suggested that the problem of approval for the euthanasia of the conscious but incapacitated aged would be even more distressing, and therefore it would be vital to relieve relatives of any involvement in this and have it arranged by some distant office.'

Of all this I am vividly aware – one has not lived through the days of the Nazis without memories which are not easily blotted out.[†] But the awareness of these appalling abuses must not blind us to the realities of a situation the severity of which will not diminish but rather increase as the percentage of old people rises and, quite possibly, the extent of Government financial aid reaches a figure beyond which it cannot go.

The doctor has a responsibility – an accountability – to the patient and the patient's family under his immediate care. But he has also a responsibility to the other patients in the long waiting queue. He has a further responsibility – to the Government, or, to put it more personally but none the less accurately, to his fellow taxpayers who provide the resources to keep the National Health Service going. The question arises as to whether some kind of consensus – I had almost said some kind of ethic – can emerge on the distribution of resources as between one part of the Health Service and another. A free-for-all could be disastrous.^{††}

[†]See also J A Baker, *The Foolishness of God*, pp 85 ff, for a sensitive discussion of this subject.

^{††}The Department of Health and Social Security has recently issued a *Discussion Document on Priorities in the Health and Personal Social Services*.

In this connexion, my attention has been drawn to a lecture recently given by Dr David Millard of the Oxford University Department of Social and Administrative Studies. It was given in July this year to the Hospital Chaplains' Fellowship in Oxford. He writes:—

'The life-time of the National Health Service has seen a burgeoning of such bodies as the National Association for the Welfare of Children in Hospital, the association to do with parents' rights to free visiting and indeed to staying in hospital with their sick children, the Patients' Association, of a more political role for MIND (formerly the NAMH), among many others. They seem to have grown up partly, at least, in response to a lack of accountability on the part of doctors for the wider implications of their work.'

He continues:—

'The administrative re-organisation of the NHS of 1974 seems to me to be another form of response to this situation – by increasing the power of the administration there has been introduced a greater requirement of accountability of the medical profession. We are seeing, I suggest, considerable national experiment in the relationship between the professions and the public, in the replacement of accountability through the forces of the market by other forms of social control more consistent with citizenship principles. Some doctors would like to keep its accountability within the profession – accountability to peers, or in terms of some form of medical audit. Now this is splendid, but it is not, in my view, enough. Neither, however, is it enough to make the professionals accountable simply to bureaucrats in medical administration, for bureaucracies themselves can be the opponents of the common good – especially when they become too large. So ultimately accountability needs to be to the recipients of the service – to the community on whose behalf the service exists. And the healthy way of managing our national medical service should maximize the participation of the consumer in the choices which are made about that service.'

Providing for a happy death

From a severely practical point of view, the main problem with which we are dealing, viz, dying well, points to several urgent needs. One is the multiplication of such institutions at St Christopher's Hospice, over which Dr Cicely Saunders presides with such distinction. Such institutions help to reverse the unfortunate trend of recent years to institutionalize medical care and dying. There is great need to enable those at home to offer the care that they can give and wish to give. These are institutions specially designed for terminal cases, where technical skills are married to deep but non-sentimental compassion, and where arrangements are such that there is time for a loving relationship

to be built up between patient and doctor and between patient and nurse. I have used two words here of great importance – *relationship* and *time*. You cannot have the one without the other. And there's the rub.

One of the main disadvantages of the National Health Service as it now operates is that so often a relationship of any depth and intimacy fails to exist between patient and doctor. The patient is passed from one doctor to another in such a way that little confidence of the one in the other has any opportunity of development. Nor is this the fault of the doctor. He is not callous. On the contrary, he longs for the development of such a relationship in depth. But the system makes this well-nigh impossible. If this is tragic in the case of ordinary patients, it is doubly tragic when the life of the patient is nearing its close. Even when the patient has relatives and friends, and when conditions are such that visits can be long and frequent, the need for a close relationship between doctor and patient, or nurse and patient, is paramount. When the patient has no relatives or friends – and there are many such cases in Britain today – and when conditions for visiting are difficult, the need is all the greater. But how *can* this exist in the big institutions for the aged and the dying which are to be found in many of our large cities?

As the percentage of aged in the population increases, pressure will have to be brought to bear on the Government not only for homes for the aged – these have increased in number in recent years – but for hospitals for terminal cases where the organization is small enough to allow of the

establishment and deepening of the trustful relationship which I now have in mind. But there can be no doubt that this will involve very heavy expenditure. And the expenditure will not only be on bricks and mortar. It will extend also to the training of young doctors and nurses specifically for the manning of these small institutions; and for this a very special kind of expertise, and, one may add, of character will be called for. In this task there should be the closest cooperation between local priests or clergymen and doctors and nurses. Hence the need for careful training for the ordinand in the care of the dying, so that wherever one of these small specialist institutions for the dying is set up, there should be a little team – doctor, nurse and priest – who will between them provide a little network of intimate caring for the dying man or woman.

References

- ¹ *On Dying Well*, published by the Church Information Office, Church House, Dean's Yard, London SW1P 3NZ, 1975.
- ² Sir John Richardson and Lord Edmund-Davies on the medical and legal aspects of the subject respectively.
- ³ Preface of the Mass for the Dead.
- ⁴ Church Information Office, 1965; pp. 52–53.
- ⁵ *op cit*, p 50.
- ⁶ *On Dying Well*, p 61.
- ⁷ *Report of Proceedings of General Synod 1976*, 7, 506.
- ⁸ SCM Press, 1973, p 29.
- ⁹ Anderson, Norman, *Issues of Life and Death*, Hodder and Stoughton, 1976, p 102.